3 Rehabilitative & Health Related Services Information

3.1 Introduction

3.1.1 General Policy

Cooperation with Agencies: Standards of practice requires the coordination of care with other agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

This section covers all Medicaid options and health related ITP services provided by therapists, school districts, charter schools, and Infant Toddler Programs (ITPs), developmental disabilities agencies (DDAs), and psychosocial rehabilitation (PSR) agencies as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- School districts, charter schools, and ITP service policy.
- Developmental disabilities agency policy.
- Rehabilitative mental health (MH) services policy.
- Prior authorization (PA).
- Claims payment.
- Electronic claims billing.
- Paper claims billing.

Note: Services provided by DDAs and PSR agencies for participants covered under the Medicaid Basic Plan are limited to diagnostic and evaluation procedures only.

Note: Services provided in schools do not impact service limitations.

3.1.2 Payment

Federal and State requirements state that Medicaid is the "payer of last resort". Third party payments must be pursued before billing Medicaid for Individuals with Disabilities Education Act (IDEA) related services.

Medicaid reimburses rehabilitative and health related services on a fee-for-service basis. Provider charges to Medicaid shall be based on reimbursement rates established by DHW for their specific provider type and specialty and shall not exceed the lowest charge of the provider to others for the same service, regardless of payment source.

Rehabilitation and health related services must be billed by providers using the appropriate procedure codes, or health related service codes. The appropriate ICD-9 code is used for the diagnosis code. This includes future versions of the *International Classification of Diseases 9th Revision Clinical Modification* (ICD-9-CM) code book.

Developmental disabilities agency and PSR providers must check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care. School-based service providers are exempt from HC referral numbers to be included on claims. If the participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid covered services.

See *Section 1.5 Healthy Connections (HC), General Provider and Participant Information,* for more information.

3.1.2.1 Determining How to Bill Units for 15 Minute Timed Codes

Several CPT codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that 1 unit equals 15 minutes. Provider's bill procedure codes for services delivered using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes. Two units should be billed when the interaction with the

participant or collateral contact is greater than or equal to 23 minutes to less than 38 minutes. Time intervals for larger numbers of units are as follows:

3 units ≥ 38 minutes to < 53 minutes

4 units ≥ 53 minutes to < 68 minutes

5 units ≥ 68 minutes to < 83 minutes

6 units ≥ 83 minutes to < 98 minutes

7 units ≥ 98 minutes to <113 minutes

8 units ≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments for billing purposes. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with the note describing the treatment. **(For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.) http://www.cms.hhs.gov/transmittals/downloads/AB001460.pdf**

3.1.3 Place-of-Service (POS) Codes

Enter the appropriate numeric code in the POS box on the CMS-1500 claim form or in the appropriate field when billing electronically.

03 School

11 Office (DDA center)

12 Home (of participant)

99 Other (community)

3.2 School District/Infant Toddler Program (ITP) Service Policy

3.2.1 Overview

Enrolled school districts, charter schools and ITPs may receive Medicaid reimbursement for rehabilitative and health related services. Schools, charter schools, and ITP may bill for the following services provided to eligible students when recommended or referred by a physician or other practitioner of the healing arts (physician's assistant, nurse practitioner, or clinical nurse specialist):

- Audio logical/speech evaluation/therapy.
- Collateral contact.
- Developmental evaluation/therapy.
- Intensive behavioral intervention (IBI).
- Interpreter services - Call the Idaho Careline at (800) 926-2588 to locate an interpreter.
- Medical equipment and supplies.
- Occupational evaluation/therapy.
- Personal care services (PCS).
- Physical therapy (PT)/evaluation and treatment.
- Psychological evaluation/therapy includes psychometric testing.
- Psychosocial rehabilitation evaluation/therapy.
- Skilled nursing services.
- Social history and evaluation.
- Transportation services.

Interpretive Services

Medicaid covers interpretation services to assist participants who are deaf or have limited English proficiency (LEP) to receive Medicaid services. Refer to the General Billing Information Handbook, *Section 2.1.2.4*. Interpreter services means those interpretive services (sign language or non-English language interpretation) that are necessary to allow the Medicaid eligible individual (child) to benefit from health related services provided by a school. The interpretive service may only be billed if the health related service for which the interpretation is needed is medically necessary.

Payment for interpretive services will not be made for the following:

- Interpretive services to assist the participant to understand information or services that are not reimbursed by Medicaid.
- Interpretive services provided by the provider of the direct service.

3.2.2 Related Services Definition

Related services are defined as the covered rehabilitative and health related services listed in, *IDAPA 16.03.09.852 School-Based Services – Coverage and Limitations*, which are provided by school districts, charter schools, and ITP, to certain students with disabilities who are enrolled in the Idaho Medicaid Program.

Eligibility for these students is determined using State Department of Education minimum eligibility criteria and assessment procedures (*IDAPA 08.02.03 Rules Governing Thoroughness*). Eligibility for children birth to three years of age is determined for those who are identified as needing early intervention services due to a developmental delay or disability in accordance with the eligibility criteria for the ITP.

3.2.3 School Districts, Charter Schools, and Infant Toddler Program (ITP) Eligibility

To be eligible for medical assistance reimbursement for covered services, a student must:

- Be identified as having an educational disability and be eligible for special education or, for children birth to three years of age, be identified as needing early intervention services due to a developmental delay or disability, or be eligible for ITP.
- Have an individualized education plan (IEP), individualized family service plan (IFSP), or services plan (SP) which indicates the need for one or more medically necessary heath-related services.
- Be 21 years of age or younger and the semester in which their twenty-first birthday falls is not finished.
- Be eligible for Medicaid.
- Be eligible for the service for which the school district, charter school or ITP is seeking reimbursement.
- Be served by a school district, charter school, ITP, or a cooperative-service agency, as defined by Idaho Code 33.03.317

3.2.3.1 Evaluations

All evaluations must support services billed to Medicaid. Evaluations must be updated as needed and accurately reflect the student's current status. They must include the following information:

- Reason the student was referred for evaluation.
- Diagnosis.
- Student's strengths, needs, and interests.
- Recommended interventions for identified needs.
- Dated signature of professional completing the evaluation.

3.2.4 Evaluation and Diagnostic Services

Evaluations must be recommended or referred by a physician or other practitioner of the healing arts (nurse practitioner, physician's assistant, clinical nurse specialist) and completed within 30 days of the date parental consent is obtained. Subsequent (annual) evaluations require only written notice to the parent(s).

3.2.5 Record Keeping

The school district, charter school, or ITP records must contain the following information on each participant:

- Referrals.
- Evaluations.
- Individualized education program (IEP), individualized family service plan (IFSP), or services plan (SP).
- Service detail report
- Other documentation as listed in *Section 3.2.5.5 Other Required Documentation*.

3.2.5.1 Referrals

Physician's orders should be located in the student's file or the physician may sign the IEP/IFSP/SP for evaluations and therapies billed to Medicaid. A physician's order is required for services and/or evaluations. It is preferred that the order is from the student's primary care provider (PCP) if the student is on the HC Program; however, it is not required. A referral form is available online at: **http://www.sde.idaho.gov/SpecialEducation/medicaid.asp.**

3.2.5.2 Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP)/Services Plan (SP)

The IEP/IFSP/SP must include the type, frequency, and duration of the service(s) provided, the title of the provider(s), and where the service will be provided if the service is provided outside of the school setting, i.e., home.

Example: Speech therapy group, two times per week, 30 minutes, by speech professional.

The IEP/IFSP/SP must also contain goals and objectives for each of the identified needs. If the goals and objectives are kept separate from the main IEP/IFSP/SP body, the IEP/IFSP/SP must list where the goals and objectives can be located. Goals and objectives must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to Medicaid.

3.2.5.3 Service Detail Report (SDR)

An SDR must be completed at the time the service was provided. The SDR must include:

- Name of the student.
- Name and title of the person providing the service.
- Date, start time and end time of the service, and duration of the service.
- Description of the service provided.
- Place of Service (POS), if provided in a location other than the school.
- Student's response documented for each direct service.

The service detail report may be included in one form by the therapy type or may be kept as a separate document.

3.2.5.4 Other Required Documentation

The school district, charter school, and ITP must also maintain records that:

- Document student reviews and/or re-evaluations and any adjustments made to the treatment plan by the appropriate professionals. Documented review of progress toward service goals must occur at least every 120 days. The 120 day reviews are considered part of the oversight requirements and are not billable separately.
- Document supervisory visits conducted by professionals when paraprofessionals are utilized.
- Document provider qualifications including required certificates, licenses, and resumes indicating qualifications for position held.
- Document that the school district, charter school, or ITP notified the student's parents of the health related services and equipment that the school district intended to bill to Medicaid. This notification must describe the service, service provider, and state the type, location, frequency, and duration of the services that will be billed.

3.2.6 Intensive Behavioral Intervention (IBI)

Intensive Behavioral Intervention (IBI) are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. This service is only available to children, birth through the month of the child's twenty-first birthday, that demonstrate self-injurious, aggressive or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, or leisure and play skills.

3.2.6.1 Excluded Services

Under the Medicaid rules in *IDAPA 16.03.09.852.01 School-Based Services – Participant Eligibility; Educational Services*, the following services are excluded from payment:

- Vocational services.
- Educational services.
- Recreational services.

3.2.7 Collateral Contact

This service may be billed and paid as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a significant other in that participant's life (i.e., parent, guardian, or other individual having a primary care relationship to the participant). The service must be:

- Provided by the appropriate professional only.

- Documented on the plan.
- Documented in the progress notes.
- Face-to-face or by telephone with the student's parent/guardian or primary care person.

General staff training, regularly scheduled parent-teacher conferences, general parent education, or treatment team meetings, even when the parent is present, are not reimbursable.

Under no circumstances can collateral contact be used to bill Medicaid for therapy to an ineligible person or be paid on behalf of a participant who is a resident of a hospital or a nursing facility (NF). Medicaid does not reimburse for parent education and/or parent support groups.

3.2.8 Provider Staff Qualifications

Medicaid reimburses for services provided by qualified professionals. The qualifications for providers of covered services are identified in, *IDAPA 16.03.09.854 School-Based Services – Provider Qualifications and Duties*.

3.2.8.1 Paraprofessionals

Paraprofessionals, such as aides or therapy technicians, may be used by the school, charter school or ITP to provide developmental therapy (DT), occupational therapy (OT), PT, PCS, and speech therapy if they are under the supervision of the appropriate professional.

The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician as defined by the scope of practice of the therapy professional. The portions of the IEP/IFSP/SP, which can be delegated to the paraprofessional, as well as amount and scope of the supervision by the professional, must be identified in the IEP/IFSP/SP. See the Medicaid rules in *IDAPA 16.03.09.854.08 School-Based Services – Provider Qualifications and Duties; Paraprofessionals*, for further clarification related to the use of paraprofessionals.

Paraprofessionals may not conduct student evaluations, or establish/adjust the IEP/IFSP/SP goals. A student's goals and objectives must be reviewed and/or re-evaluated by the appropriate professional and the IEP/IFSP/SP adjusted as the professional's individual practice dictates.

Any change in the student's condition inconsistent with planned progress or treatment goals necessitates a documented re-evaluation by the professional before further treatment is carried out.

3.2.9 Estimated Annual Expenditure Match

The school district, charter school, or ITP is responsible for certification of the state match portion of the Medicaid payment. The state match is calculated at the Federal Financial Participation (FFP) rate effective for the current federal year.

School districts, charter schools, or ITP must annually calculate and document, as part of their fiscal records, the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. Federal funds cannot be used as the state's portion of match for Medicaid service reimbursement. This documentation needs to include only the amount of dollars that have been certified and where the dollars originated. It is not necessary to designate how the dollars were spent for the purpose of certifying the match. The appropriate matching funds will be handled in the following manner:

- Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings.
- School districts will send DHW the matching funds, either by check or ACH electronic funds transfers.
- Matching funds will be held in an interest bearing trust account. The average daily balance during a month must exceed $100 in order to receive interest for that month.
- The payments to the districts will include both the federal and non-federal share (matching funds).
- Matching funds from the district cannot be from federal funds or used to match any other federal funds.

- Checks should be sent to DHW at the following address:

  Department of Health and Welfare
  Management Services Business Office
  PO Box 83720
  Boise, ID 83720-0036
  (208) 334-5909

- Contact the Fiscal Operations Supervisor at the above address if the school district wants to make electronic fund transfer payments for the matching funds.
- Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle.
- If sufficient matching funds are not received in advance, all Medicaid payments to the school district, charter school, or ITP will be suspended and the school district, charter school, or ITP will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle.

The Department of Health and Welfare will provide the school districts, charter schools, or ITP a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. The school districts, charter schools, or ITP will estimate the amount of their next billing and the amount of matching funds needed to pay DHW. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. If the school district, charter school, or ITP has any questions, please direct those questions to the Fiscal Operations Supervisor.

3.2.10 Payment for Services

Payment for school districts, charter schools, or ITP health related services must be in accordance with DHW established rates. Providers must accept DHW's payment as payment in full. Providers may not bill Medicaid participants for the balance.

A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services billed under the school district, charter school, or ITP provider number.

Third party recovery (TPR), such as private insurance, must be exhausted before DHW is billed. Proof of billing other third party payers is required.

Failure to provide services for which reimbursement has been received or to comply with these rules and regulations established by DHW is cause for recoupment of the federal share of payments for services, sanctions, or both.

Providers must give DHW immediate access to all information required to review compliance with these rules and regulations.

3.2.11 Prior Authorization (PA)

Prior authorization is required for certain medical equipment and supplies. See *Section 3 Durable Medical Equipment Guidelines,* for additional information.

Prior authorization will be based on a determination of medical necessity made by DHW or its designee.

If PA is required, the PA number must be included on the claim.

See *Section 2.3.2 Medicaid Prior Authorization (PA)*, for more information on billing services that require PA.

3.2.12 Procedure Codes

All claims submitted must contain one or more of the following 5-digit health related service procedure codes for billing. If a modifier is identified with the code, the modifier must be used with the code to bill for services.

3.2.12.1 Evaluation Services

Evaluation and information gathering services not necessarily associated with treatment are as follows:

Service	Procedure Code	Description
Speech evaluation through the school district	**92506**	Evaluation of speech, language, voice, communication, and/or auditory processing and/or aural rehabilitation status. Specify exact time. 1 Unit = 1 evaluation
Hearing evaluation through the school district	**V5008**	Hearing screening. Specify exact time. 1 Unit = 15 Minutes.
PT evaluation through the school district	**97001**	PT evaluation. Specify exact time. 1 Unit = 1 evaluation
OT evaluation through the school district	**97003**	OT evaluation. Specify exact time. 1 Unit = 1 evaluation
DT comprehensive evaluation	**H2000**	Comprehensive multidisciplinary evaluation. Specify exact time. 1 Unit = 15 Minutes.
Psychological testing for diagnosis/ evaluation through the school district	**96101**	Psychological testing (including psycho diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, Rorschach, MMPI), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report. Specify exact time. 1 Unit = 1 Hour.
Psychological testing for diagnosis/evaluation through the school district	**96102**	Psychological testing (including psycho diagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities, e.g., WAIS, MMPI), with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face. 1 Unit = 1 Hour.
Psychological testing for diagnosis/ evaluation through the school district	**96103**	Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI), administered by a computer, with qualified healthcare professional interpretation and report. 1 Unit = 1 Test.
Psychosocial rehabilitation evaluation through the school district	**H0031**	Mental health (MH) assessment, by non-physician. Specify exact time. 1 Unit = 15 Minutes.
Psychiatric diagnostic interview exam through the school district	**90801**	Psychiatric diagnostic interview examination. Specify exact time. 1 Unit = 15 Minutes.

Service	Procedure Code	Description
Social history/evaluation through the school district	**T1023**	Evaluation to determine appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
Collateral contact	**90887**	Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Specify exact time. 1 Unit = 15 Minutes. **Note:** This code cannot be used for general staff training, regularly scheduled parent-teacher conferences, general parent education or for parent support groups or for treatment team meetings, even when the parent is present. Collateral contact cannot be provided by paraprofessionals

3.2.12.2 Speech/Hearing Therapy

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid.

All speech and hearing claims must include one of the following procedure codes:

Service	Procedure Code	Description
Individual speech/hearing therapy, professional through the school district	**92507** **HO** Modifier Required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), individual. Specify exact time. 1 Unit = 15 Minutes.
Group speech/hearing therapy, professional through the school district	**92508** **HO** Modifier Required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), two or more individuals. Specify exact time. 1 Unit = 15 Minutes.
Individual speech/hearing therapy, technician through the school district	**92507** **HM** Modifier Required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), individual. Specify exact time. 1 Unit = 15 Minutes.
Group speech/hearing therapy, technician through the school district	**92508**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.2.12.3 Physical Therapy (PT)

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid.

All physical therapy claims must include one of the following procedure codes.

Service	Procedure Code	Description
Individual PT, professional through the school district	**97110** **HO** Modifier Required	Therapeutic procedure, in one or more areas. Therapeutic exercises to develop strength and endurance, range of motion and flexibility, individual. Specify exact time. 1 Unit = 15 Minutes.
Group PT, professional through the school district	**97150** **HO** Modifier Required	Therapeutic procedure(s) with two or more individuals. Specify exact time. 1 Unit = 15 Minutes.
Individual PT, technician through the school district	**97110**	Therapeutic procedure, one or more areas. Therapeutic exercises to develop strength and endurance, range of motion and flexibility, individual. Specify exact time. 1 Unit = 15 Minutes.
Group PT, technician through the school district	**97150**	Therapeutic procedure(s) with two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.2.12.4 Occupational Therapy (OT)

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid.

All OT claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Individual OT, professional through the school district	**97530** **HO** Modifier Required	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), individual. Specify exact time. 1 Unit = 15 Minutes.
Group OT, professional through the school district	**97530** **HO** and **HQ** Modifiers Required	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), two or more individuals. Specify exact time. 1 Unit = 15 Minutes.
Individual OT, technician through the school district	**97530**	Therapeutic activities, (direct one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), individual. Specify exact time. 1 Unit = 15 Minutes.

3.2.12.5 Developmental Therapy (DT)

Medicaid reimbursement for individual and group DT is limited to those students who have a developmental disability (DD) according to *IDAPA 16.03.10. 501 Medicaid Basic Plan Benefits; Developmental Disability Determination Standards* – Eligibility, through *503 Developmental Disability Determinations – Test Instruments.*

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid.

All DT claim forms must include one of the following procedure codes

Service	HCPCS	Description
Individual DT through the school district	**H2014**	Skills training and development, individual. Specify exact time. 1 Unit = 15 Minutes.
Group DT through the school district	**H2014** **HQ** Modifier Required	Skills training and development, two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.2.12.6 Intensive Behavioral Interventions (IBI)

Treatment must be in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluation, IEP/IFSP/SP, and other required services to be paid.

All IBI claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
IBI, professional	**H2019**	Therapeutic behavioral services. 1 Unit = 15 Minutes.
IBI, paraprofessional	**H2019** **HM** Modifier Required	Therapeutic behavioral services. 1 Unit = 15 Minutes.
IBI consultation, professional	**H0024**	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude). Specify exact time. 1 Unit = 15 Minutes.

3.2.12.7 Psychosocial Rehabilitation (PSR)

Medicaid reimbursement for individual and group PSR is limited to those students who meet eligibility criteria outlined in *IDAPA 16.03.09.851 Medicaid Basic Plan Benefits; School-Based Services Participant Eligibility*. Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid.

All PSR claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Individual PSR through the school district	**H2017**	PSR services. Professional only, individual. Specify exact time. 1 Unit = 15 Minutes.
Group PSR through the school district	**H2017** **HQ**	PSR services. Professional only, two or more individuals. Specify exact time.

Service	Procedure Code	Description
	Modifier Required	1 Unit = 15 Minutes.

Psychotherapy

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluation, IEP/IFSP/SP, and other required services to be paid.

All psychotherapy claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Individual psychotherapy (includes interactive psychotherapy) through the school district	**90899**	Unlisted psychiatric service. This code was previously, Individual Psychiatric Therapy. This code is reimbursed per 15 minute units. **Note:** This is an interim code to be used by schools to be able to bill for psychotherapy services. This code replaces **90804**, **90806**, and **90808**.
Group psychotherapy through the school district	**90853**	Group psychotherapy (other than of a multiple, family group). Two or more students. Professional only. Specify exact time. 1 Unit = 15 Minutes.
Family psychotherapy through the school district	**90847**	Family psychotherapy (conjoint psychotherapy) (with patient present). Professional only. Specify exact time. 1 Unit = 15 Minutes.
Family medical psychotherapy without patient present through the school district	**90846**	Family psychotherapy without patient present. Must be face-to-face with at least one family member present. The participant must be the focus of services. Goals of treatment must be specified on the participants individualized treatment plan. 1 Unit = 15 Minutes.

3.2.12.8 Nursing Services

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must deliver and document all evaluations, IEP/IFSP/SP, and other required services to be paid. They do not include tasks that can be delegated to unlicensed assistive personnel by a registered nurse (RN) once proper training is provided and competency assessed.

All nursing services claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Nursing services, licensed practical nurse (LPN) skilled	**T1003**	LPN services. Specify exact time. 1 Unit = 15 Minutes.
Nursing services, RN skilled	**T1002** **TD** Modifier Required	RN services. Specify exact time. 1 Unit = 15 Minutes.
Nursing services – RN oversight	**T1002**	RN oversight. Specify exact time. 1 Unit = 15 Minutes.

3.2.12.9 Personal Care Services (PCS)

Personal care services include medically oriented tasks related to the student's physical or functional requirements such as basic personal care and grooming, assistance with eating, assistance with toileting, or other tasks delegated by an RN.

Personal care services must be:

- Ordered by a physician, or another authorized provider.
- Based on a written plan of care that has been developed by an RN, or another authorized provider.
- Supervised and monitored by an RN, or QMRP, The RMS must identify the need for supervision.

Personal care service providers must complete all required records to be paid.

All PCS claim forms must include one of the following procedure codes:

Service	Procedure Codes	Description
PCS	**T1004**	Services of an aide. Specify exact time. 1 Unit = 15 Minutes.
PCS, RN assessment	**G9001**	Coordinated care fee, initial rate. Flat rate paid for 1 assessment, per year.
PCS, supervising RN visit	**T1001**	Nursing assessment/evaluation. Flat rate paid for no more than 1 visit per month.

3.2.12.10 Transportation

Medicaid reimbursement for transportation services can only be billed when:

- The student requires special transportation assistance.
- The transportation occurs in a vehicle specially adapted to meet the needs of a student with a disability.

Special transportation assistance can include a wheelchair lift or an attendant when the attendant is needed for the health and safety of the student. Both the Medicaid covered service and the need for transportation must be included on the IEP/IFSP/SP.

All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to receive reimbursement.

Medicaid payments are available for transportation for school-aged children from home to school or from school to home who are receiving a service. Medicaid will continue to reimburse transportation costs related to school-aged children who are transported from school or home to a non-school-based direct medical service provider that bills under the Medicaid program, and from the non-school-based provider to school or home.

All transportation claim forms must include at least one of the following procedure codes:

Service	Procedure Code	Description
Transportation, attendant rate	**T2001**	Non emergency transportation, patient attendant/escort. Specify exact time. 1 Unit = 15 Minutes.
Transportation mileage rate	**A0080**	Non-emergency transportation, per mile, vehicle provided by volunteer (individual or organization), with no vested interest. Specify number of miles from pick-up to delivery.

3.2.12.11 Medical Equipment and Supplies

Authorization is limited to equipment and supplies primarily used and medically necessary for an individual student within the school setting or natural learning environment as indicated by the IEP or IFSP. When necessary, authorization may also be given for equipment and supplies that are used in both the home and the school but are too large to transport back and forth or would be unsafe or unsanitary to transport back and forth. Other equipment and supplies (such as wheelchairs, diapers, dressing supplies, or catheters) which are used primarily at home, but also at school, are the responsibility of the primary caretakers to obtain and provide to the school.

Medical equipment and supplies which have been paid for by Medicaid funds are for the exclusive use of the student for whom they were ordered or billed. If the student transfers to another school, or leaves the school at which the equipment or supply was obtained, the supply or equipment must be transferred with the student.

Providers must complete an evaluation and all other required records and documentation to receive reimbursement.

All medical equipment claim forms must include the following procedure code:

Service	Procedure Code	Description
Medical equipment	**E1399**	DME, miscellaneous. 1 Item = 1 Unit. **Note:** All items require PA and invoice or MSRP.

3.3 Developmental Disabilities Agency (DDA) Policy

3.3.1 Overview

Developmental disabilities agencies must provide rehabilitative services consistent with the needs of persons with developmental disabilities (DD) and as outlined on the participant's required plan of service. See *IDAPA 16.04.11 Developmental Disabilities Agencies (DDA)*.

Note: Services provided by DDAs for participants covered under the Medicaid Basic Plan are limited to diagnostic and evaluation procedures only.

3.3.2 Program Requirements

See *IDAPA 16.04.11 Developmental Disabilities Agencies (DDA)*, for assessment, plan, and record keeping requirements for DDA plan of service updates.

The interdisciplinary team must meet at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant.

3.3.2.1 Covered Service Limits

The maximum amount reimbursable in any calendar year for each participant for a combination of all evaluation, assessment, and diagnostic services billed by all therapy providers is 12 hours.

The combination of developmental therapy (DT), psychotherapy, supportive counseling, speech and hearing therapy, physical therapy (PT), occupational therapy (OT), and intensive behavioral intervention (IBI) is limited to no more than 22 hours per week.

Only one type of therapy is reimbursed during any single time period. PCS are not considered therapy for the purpose of this description. No therapy service is reimbursed during periods when the participant is being transported to and from the agency. For specific therapy limitations, based on type of service, see the appropriate sections of these guidelines.

3.3.2.2 Non-Covered Services

See *IDAPA 16.03.10.653.04 Excluded Services, for Developmental Disability Agencies* the following services are excluded from payment:

- Vocational services.
- Educational services.
- Recreational services.

Developmental disabilities agencies may only provide services in a school-based setting when working under a contract with the school. Only the school may bill Medicaid for these contracted services.

3.3.3 Prior Authorization (PA)

Developmental disabilities agency services for adults require PA from DHW or its designee. If PA is required, the PA number must be indicated on the claim, or the payment will be denied. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval.

When requesting PA, specify which service will be rendered.

When billing electronically, more than one PA number is allowed on the claim. Only one PA number is allowed on paper claims.

For HC participants, PA will be denied if the requesting provider is not the PCP or a referral has not been obtained.

See *Section 2.3.2 Medicaid Prior Authorization (PA), General Billing Information* for more information on billing services that require PA.

3.3.3.1 Case Record Format

The case record must be divided into program and discipline areas identified by tabs, including plan of service, medical, social, psychological, speech, and developmental (as applicable).

3.3.3.2 Record Keeping

To facilitate payment from Medicaid, DDA records must contain the following information on each participant:

- Face sheet: Profile sheet containing necessary identifying information on the participant and family, eligibility documents, and Medicaid number.
- Physician's order: A written order signed and dated by the physician for all assessments completed.
- Social history: Social history and assessment containing relevant social information on the participant and family.
- History/physical: A medical history and physical examination completed and signed by a physician.
- Assessments: Assessment forms, as applicable, and narrative reports signed and dated by the respective examiners for each discipline covering those items assessed and recommendations for services.

3.3.4 Collateral Contact

Contact may be billed and paid as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a significant other in that participant's life (i.e., parent, guardian, or other individual having a primary treatment relationship to the participant).

The service must be:

- Authorized on the plan of service.
- Documented in the progress notes.

Under no circumstances can collateral contact be used to bill Medicaid for therapy to an ineligible person, or be paid on behalf of a participant who is a resident of a public institution or an NF, including an Intermediate Care Facility (for Developmentally Disabled)/ Mentally Retarded (ICF/MR). See the rules in *IDAPA 16.03.10.650 Medicaid Enhanced Plan Benefits; Developmental Disabilities Agencies (DDA), through 656 DDA Services – Provider Reimbursement*, for specific requirements.

3.3.5 Psychotherapy

Reimbursement for Medicaid Enhanced Plan participants for individual and group psychotherapy services is limited to a maximum of 45 hours in a calendar year (alone or in combination with supportive counseling) and includes the following:

- Individual psychotherapy provided in accordance with the plan of service.
- Group psychotherapy in accordance with the plan of service.
- Family psychotherapy, which must include the participant and at least one other family member in accordance with the plan of service.
- Individual and group interactive psychotherapy in accordance with the plan of service.

Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient. It is used when a patient has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment or the receptive communication skills to understand the clinician if they were to use ordinary language for communication.

Psychotherapy services must be provided by appropriately credentialed professionals only. See the rules in *IDAPA 16.04.11.712.02 Medicaid Enhanced Plan Benefits; Psychotherapy; Staff Qualification for Psychotherapy Services*, for a complete listing of qualified professionals.

3.3.5.1 Supportive Counseling

Medicaid reimbursement for supportive counseling is limited to a maximum of 45 hours in a calendar year (alone or in combination with psychotherapy).

Supportive counseling is a method used by qualified professionals to assist individuals with DD to learn how to solve problems and make decisions about personal, social, relationship, and other interpersonal concerns. Supportive counseling does not seek to reach unconscious material.

Supportive counseling must be provided by appropriately credentialed professionals only. See the rules in I*DAPA 16.04.11.726.03 Developmental Disabilities Agencies (DDA); Supportive Counseling; Staff Qualifications*, for qualifications.

3.3.6 Community Crisis Supports

Community crisis support includes intervention for participants in crisis situations to ensure their health and safety or prevent hospitalization or incarceration of a consumer. Community crisis support may include:

- Loss of housing, employment, or reduction of income.
- Risk of incarceration.
- Risk of physical harm.
- Family altercation or other emergencies.

Community crisis support is the choice of the participant and may be billed by service coordinators, plan developers (must be a targeted service coordinator), Plan Monitors (must be a targeted service coordinator), DDAs, and all DD and Idaho State School and Hospital – Nampa (ISSH) Waiver providers except:

- Specialized medical equipment agencies.
- Non-medical transportation providers.
- Personal emergency response agencies.
- Home delivered meal providers.

Community crisis supports is limited to a maximum of 20 hours per crisis, for a period of five consecutive days. Services may not exceed 20 hours per crisis.

The Regional Care Manager will review and authorize each crisis service to make determination for appropriateness and financial reimbursement. Providers must get either a written or verbal approval for community crisis supports prior to billing.

Providers must identify on the Crisis Authorization Worksheet the factors contributing to the crisis and develop a proactive strategy that will address the factors that result in crisis.

3.3.7 Speech-Language Pathology Services

Speech-language pathology services are limited to 40 visits per calendar year before a prior authorization is necessary. Treatment must be rendered by a licensed speech-language pathologist who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Hearing, and Language Association (ASHA) or will be eligible for certification within one year of employment with the DDA.

3.3.7.1 Prior Authorization (PA) for Speech-Language Pathology Services

Providers must submit a PA request to DHW when additional visits are needed over 40 speech-language pathology visits in a calendar year. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated. Documentation needed for determining the need for additional visits is as follows:

- Referral from Healthy Connections (HC) Primary Care Provider (PCP) when applicable. (For HC participants, PA will be denied if the requesting provider is not the PCP or a referral is not obtained).
- Current physician's order identifying the POC and why the therapy is medically necessary.
- SLP evaluation.
- SLP update/progress reports.
- Treatment plan which identifies diagnosis, type, frequency, and expected duration of treatment, along with the anticipated outcomes.
- Copies of other therapy plans to ensure coordination of care (such as IFSP or IEP).
- Copies of the last 30 days therapy notes.
- Number of visits being requested.
- Date range of requested services.

The Medical Care Unit is responsible for speech-language pathology PAs for visits in excess of 40 per calendar year. Mail or fax PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904 in the Boise calling area
Fax: (208) 332-7280

When a PA is required, the PA number must be included on the claim, or the service will be denied. See *Section 2.3.2 Medicaid Prior Authorization (PA)*, for more information on billing services that require PA.

3.3.8 Physical Therapy (PT) and Occupational Therapy (OT) Services

Physical therapy services are limited to 25 visits per calendar year before prior authorization is required. Treatment must be provided directly by a licensed physical therapist in accordance with the plan of care.

Occupational therapy services are limited to 25 visits per calendar year before prior authorization is required. Treatment must be provided directly by a licensed occupational therapist in accordance with the plan of care.

3.3.8.1 Prior Authorization (PA) of Physical Therapy (PT) and Occupational Therapy (OT) Services

Providers must submit a PA request to DHW when more than 25 visits of OT or PT are necessary in a calendar year. Idaho Medicaid uses nationally recognized criteria in making PA determinations; and PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated. Documentation needed for determining the medical necessity for additional visits is as follows:

- Referral from Healthy Connections Primary Care Provider when applicable. (For HC participants, PA will be denied if the requesting provider is not the PCP or a referral is not obtained)
- Current physician's order identifying the plan of care (POC) and why the therapy is medically necessary
- OT or PT evaluation

- OT or PT update and progress reports
- Treatment POC which identifies diagnosis, modalities, frequency of treatment, expected duration of treatment and anticipated outcomes
- Copies of other therapy plans: IFSP or IEP
- Copies of the last 30 days therapy notes
- Number of visits being requested
- Date range of requested services

The following procedure codes require PA by DHW. In this case, the therapist along with the physician, nurse practitioner, or physician assistant must provide information in writing to DHW that documents the medical necessity of the modality/procedure being requested.

The procedures which always require a PA are as follows:

Procedure Code	Description
97039	Unlisted modality (specify type and time if constant attendance).
97139	Unlisted therapeutic procedure (specify).
97537	Community/work reintegration training (*e.g.*, shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes.

The Medical Care Unit is responsible for PA of visits in excess of 25 OT or 25 PT visits per calendar year, and for the three codes listed above. Mail or fax PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904 in the Boise calling area
Fax: (208) 332-7280

When a PA is required, the PA number must be included on the claim, or the service will be denied. See *Section 2.3.2 Medicaid Prior Authorization (PA)*, *General Billing Information* for more information on billing services that require PA.

3.3.9 Developmental Therapy (DT)

Developmental therapy may be provided seven days a week, as long as the hours per week do not exceed the 22 hour limit. When billing for services, bill for the calendar week from Sunday through Saturday. Services must be consecutive dates when billing a date span.

Developmental therapy must be provided in accordance with, *IDAPA 16.04.11 Developmental Disabilities Agencies (DDA).*

3.3.10 Intensive Behavioral Intervention (IBI)

Intensive behavioral intervention are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. This service is only available to children with DD through the month of their twenty-first birthday who demonstrate self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, leisure and play skills. IBI have a lifetime limit of 36 months.

3.3.11 Specialized Services to Nursing Facility Participants

Medicaid authorizes DT and psychotherapy for nursing facility participants who meet the following criteria:

- The participant has been identified through the initial Pre-Admission Screening Annual Resident Review (PASARR) process as being mentally retarded or having a related condition.
- The participant has been identified through the PASARR level II process as requiring DT and psychotherapy.
- The participant, when informed of their options for service delivery, chooses a DDA to provide that service.
- Services are provided in accordance with the plan of service and are supported by the assessment, directed toward the achievement of specific measurable objectives, and include target dates for completion.

The RMS is responsible for assuring the participant is identified as needing specialized services and for assigning a PA number to the agencies. The PA number must be entered on the claims submitted to EDS for payment.

Providers who bill for specialized services to nursing facility participants should use their usual agency based procedure codes.

3.3.12 Procedure Codes

The Idaho Medicaid Program uses the following procedure codes. All claims submitted must contain one or more of the following 5-digit procedure codes for billing DDA services.

3.3.12.1 General Services

Procedure codes for evaluation and information gathering services not necessarily associated with treatment are as follows:

Service	Procedure Code	Description
Psychological test for diagnosis and assessment	**96101**	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, *e.g.,* WAIS, Rorschach, MMPI) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report. 1 Unit = 1 Hour.
Psychological test for diagnosis and assessment	**96102**	Psychological testing (including psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, *e.g.*, WAIS, MMPI) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face. 1 Unit = 1 Hour.
Psychological test for diagnosis and assessment	**96103**	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified healthcare professional interpretation and report. 1 Unit = 1 Test.
Psychiatric diagnostic interview	**90801**	Psychiatric diagnostic interview examination. Physicians should use **U1** modifier. 1 Unit = 15 Minutes.
Social history	**T1028**	Assessment of home, physical and family environment, to determine suitability to meet participant's medical needs. This service may be performed by licensed practical nurse (LPN) or registered nurse (RN) as well as other qualified staff. This code should be used as part of the initial intake only. It is not considered an ongoing

Service	Procedure Code	Description
		service. Specify exact time. 1 Unit = 15 Minutes.
Collateral contact	**90887**	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist participant. This code cannot be used for staffing. Specify exact time. 1 Unit = 15 Minutes.
Community crisis supports	**H2011**	Intervention for participant in crisis situations. (See *IDAPA 16.03.10, Subsection 613.13* for specific requirements). Service is limited to a maximum of 20 hours per crisis, for 5 consecutive days. Service may not exceed 20 hours per crisis. 1 Unit = 15 Minutes.
Interpretation, Bilingual Translation	**8296A**	Interpretation for bilingual translation 1 Unit = 1 Hour
Interpreter, non-certified	**T1013**	Sign language interpretation services for the deaf. 1 Unit = 15 Minutes
Pharmacological management	**90862**	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, or clinical nurse specialist-psychiatric. 1 Unit = 1 Visit.

3.3.12.2 Speech-Language Pathology Services

Speech-language pathology services are limited to 40 visits, per calendar year. Treatment must be provided by a licensed speech-language pathologist who possesses a certificate of clinical competence in speech-language pathology from ASHA or will be eligible for certification within one year of employment with the DDA.

All services must be based on a current assessment, be included on the plan of service, and contain all other required documentation to be paid.

All speech-language pathology claims must include one of the following procedure codes:

Service	Procedure Code	Description
Speech and language assessment	**92506**	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. Specify exact time. 1 Unit = 15 Minutes.
Individual speech and hearing therapy	**92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), individual. Specify exact time. 1 Unit = 15 Minutes.
Group speech and hearing therapy	**92508**	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation), two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.3.12.3 Physical Therapy (PT)

Physical Therapy services are limited to 25 treatment visits, per calendar year. Treatment must be provided by or under the direct supervision of a licensed physical therapist.

All services must be based on a current assessment, be included on the plan of service, and contain all other required documentation to be paid.

All PT claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
PT assessment	**97001**	PT evaluation. Specify exact time. 1 Unit = 15 Minutes.
Individual PT	**97110**	Therapeutic procedure, one or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility, individual. Specify exact time. 1 Unit = 15 Minutes.
Group PT	**97150**	Therapeutic procedure(s), two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.3.12.4 Developmental Therapy (DT) and Occupational Therapy (OT)

Developmental Therapy treatment must be provided by or under the supervision of a qualified developmental specialist.

Occupational therapy assessments and therapy can only be provided by a licensed occupational therapist.

All services must be based on a current assessment of the participant, be documented on the plan of service, and include all other required documentation to be paid.

Billing for children's DT services will be allowed only for work with participants who are 0-17. Adult billing codes should be used for participants age 18+ (Some cases will be allowed to use children's DT codes for those participants age 18-21 who continue to access children's programs.)

All occupational or developmental therapy claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Comprehensive DT assessment	**H2000**	Comprehensive multidisciplinary evaluation. Specify exact time. 1 Unit = 15 Minutes.
DT individual Center Children 0-17	**H2014**	Skills training and development. Specify exact time. 1 Unit = 15 Minutes.
DT individual Home/community Children 0-17	**H2021**	Community based wrap-around services, individual. Specify exact time. 1 Unit = 15 Minutes.
DT group Home/community Children 0-17	**H2021** **HQ** Modifier Required	Community based wrap-around services, two or more individuals. Specify exact time. 1 Unit = 15 Minutes.
DT group Center Children 0-17	**H2014** **HQ** Modifier	Skills training and development, two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

Service	Procedure Code	Description
	Required	
DT individual Center Adult 18+	**H2032**	Individual activity therapy. 1 Unit = 15 Minutes. (PA required for adults in the DD care management process)
DT individual Home/community Adult 18+	**97537**	Home/community and/or work reintegration training, individual. 1 Unit = 15 Minutes. (PA required for adults in the DD care management process)
DT group Home/community Adult 18+	**97537** **HQ** Modifier Required	Home/community and/or work reintegration training, two or more individuals. 1 Unit = 15 Minutes. (PA required for adults in the DD care management process)
DT group Center Adult 18+	**H2032** **HQ** Modifier Required	Group activity therapy. 1 Unit = 15 Minutes. (PA required for adults in the DD care management process)
OT assessment	**97003**	OT evaluation. Specify exact time. 1 Unit = 15 Minutes.
OT (individual)	**97535**	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, individual. Specify exact time. 1 Unit = 15 Minutes.
OT (group)	**97535** **HQ** Modifier Required	Self-care/home management training (e.g., ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, two or more individuals. Specify exact time. 1 Unit = 15 Minutes.

3.3.12.5 Psychotherapy Treatment

Medicaid reimbursement for individual and group psychotherapy services is limited to a maximum of 45 hours in a calendar year (alone or in combination with supportive counseling). Psychotherapy services must be provided by the professionals listed in, *IDAPA 16.04.11.712.02 Developmental Disabilities Agencies (DDA); Psychotherapy; Staff Qualifications for Psychotherapy*.

All services must be based on a current assessment of the participant, be included on the plan of service, and contain all other required documentation to be paid.

All psychotherapy claim forms must include one of the following procedure codes:

Service	Procedure Code	Description
Individual medical psychotherapy	**H0004**	Behavioral health counseling and therapy, individual. Physicians use **U1** modifier. Specify exact time. 1 Unit = 15 Minutes.
Group medical psychotherapy	**90853**	Psychotherapy (other than of a multiple-family group), two or more individuals. Physicians use **U1** modifier. Specify exact time.

		1 Unit = 15 Minutes.
Family medical psychotherapy	**90847**	Family psychotherapy (conjoint psychotherapy)(with patient present). Physicians use **U1** modifier. Specify exact time. 1 Unit = 15 Minutes.

3.3.12.6 Supportive Counseling

Medicaid reimbursement for supportive counseling is limited to a maximum of 45 hours in a calendar year (alone or in combination with psychotherapy). Supportive counseling must be provided by qualified professional as outlined in *IDAPA 16.04.11.726.03 Developmental Disabilities Agencies (DDA); Supportive Counseling; Staff Qualifications*.

All services must be based on a current assessment of the participant, be included on the plan of service, and contain all other required documentation to be paid.

All supportive counseling claims must include the following procedure code and modifier.

Service	Procedure Code	Description
Supportive counseling	**H0004** **HM** Modifier Required	Behavioral health counseling delivered by a LSW, individual Specify exact time. 1 Unit = 15 Minutes.

3.3.12.7 Intensive Behavioral Intervention (IBI)

Intensive behavioral intervention services require a PA by DHW and must list the need for the service on the plan of service including the hours of service and the measurable outcomes.

All IBI claims must include one of the following procedure codes and modifiers.

Service	Procedure Code	Description
IBI, professional	**H2019**	Therapeutic behavioral services. Specify exact time. 1 Unit = 15 Minutes. PA required.
IBI, paraprofessional	**H2019** **HM** Modifier Required	Therapeutic behavioral services. Specify exact time. 1 Unit = 15 Minutes. PA required.
IBI, consultation	**H0024**	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with audiences to affect knowledge and attitude). Specify exact time. 1 Unit = 15 Minutes. PA required.
Comprehensive IBI assessment	**T2024**	Service assessment. Specify exact time. 1 Unit = 15 Minutes. PA required.

3.3.12.8 Specialized Services to Nursing Facility Participants

Regional Medicaid services prior authorize DT and psychotherapy services for nursing facility participants.

All DT and psychotherapy claims must include one of the following procedure codes and modifiers:

Service	Procedure Code	Description
DT evaluation for nursing facility participants	**H2000** **U4** Modifier Required	Comprehensive multidisciplinary evaluation. 1 Unit = 15 Minutes.
DT/individual for nursing facility participants	**H2014** **U4** Modifier Required	Skills training and development, individual. Specify exact time. 1 Unit = 15 Minutes.
DT/group for nursing facility participants	**H2014** **U4** and **HQ** Modifier Required	Skills training and development, two or more individuals. Specify exact time. 1 Unit = 15 Minutes.
Individual psychotherapy for nursing home participants	**H0004** **U4** Modifier Required	Behavioral health counseling and therapy, individual. Physicians use **U1** modifier. Specify exact time. 1 Unit = 15 Minutes.
Group psychotherapy for nursing facility participants	**90857** **U4** Modifier Required	Group interactive psychotherapy (other than of a multiple-family group), two or more individuals. Physicians use **U1** modifier. Specify exact time. 1 Unit = 15 Minutes.
Family psychotherapy for nursing facility participants	**90847** **U4** Modifier Required	Family psychotherapy (conjoint psychotherapy) (with patient present). Physicians use **U1** modifier. Specify exact time. 1 Unit = 15 Minutes.

3.4 Rehabilitative Mental Health (MH) Services Policy

3.4.1 Overview

Rehabilitative MH services (psychosocial rehabilitation (PSR) services) include treatment, rehabilitation, and supportive services. The goal of rehabilitative services is to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community.

Note: Services provided by PSR agencies for participants covered under the Medicaid Basic Plan are limited to diagnostic and evaluation procedures only.

3.4.2 Provider Enrollment and Credentialing

In order to become enrolled as a PSR provider the provider applicant must meet the requirements established through the credentialing program. All existing PSR providers must meet the requirements of the credentialing program on a schedule established with the DHW.

All locations where Medicaid PSR services are provided must be registered with DHW and must have a valid provider agreement.

3.4.3 Participant Eligibility

Children with a serious emotional disturbance (SED) are eligible for rehabilitative mental health services. See *IDAPA 16.03.10.112.02.a – d Medicaid Enhanced Plan Benefits; Enhanced Outpatient Mental Health Services – Participant Eligibility; Eligibility Criteria for Children*, for qualifying criteria. Also, participants who are 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas on either a continuous or an intermittent basis are eligible for these services. Specific diagnoses and functional information can be found at *IDAPA 16.03.10.112.03.a - b Medicaid Enhanced Plan Benefits; Enhanced Outpatient Mental Health Services – Participant Eligibility; Eligibility Criteria for Adult*.

3.4.4 Prior Authorization (PA)

Prior authorization is required for all rehabilitative MH services except comprehensive assessments and is obtained from DHW.

See *Section 2.3.2 Medicaid Prior Authorization (PA)*, *General Billing Information* for more information on billing services that require PA.

3.4.5 Non-Covered Services

Treatment services are not reimbursed if rendered to participants residing in inpatient medical facilities (including nursing homes) unless specifically approved by RMS through the PASARR Program. Also excluded are recreational and social activities, job training, job placement services, or job specific interventions, staff performance of household tasks and chores, and treatment services for persons other than the identified participant.

Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the services, leaving messages, scheduling appointments, transporting participants, or documenting services.

3.4.6 Covered Services

A combination of any evaluation or diagnostic services is limited to a maximum of six hours annually under the PSR Program.

Note: Participants are subject to a yearly limit of 12 hours for all MH related evaluation and diagnostic services.

Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler Program (ITP). The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the ITP may bill Medicaid for these contracted services when provided in accordance with, *IDAPA 16.03.09.850 Medicaid*

Basic Plan Benefits; School-Based Services – Definition through 856 School-Based Services – Quality Assurance.

3.4.7 Limitations

3.4.7.1 Psychotherapy

Individual, family, and group psychotherapy services are limited to a maximum of 24 hours annually.

3.4.7.2 Crisis Intervention Services

Community crisis support services are limited to a maximum of 20 hours during any consecutive five day period. Ongoing crisis services require PA by DHW. Crisis services should be documented and maintained in the participant's file, along with the written approval. Crisis hours are authorized on a per incident basis.

3.4.7.3 Psychosocial Rehabilitation (PSR)

Any combination of individual and group PSR services is limited to 10 hours per week. Services in excess of 10 hours require additional review and PA by DHW.

3.4.8 Payment

Payment for rehab option services is made directly to the provider agency (with exception of PSR school-based services) in accordance with the rates established by DHW for the specific services.

For services paid at the 15 minute incremental rate, providers will not be reimbursed for more than one contact during a single 15 minute time period.

Note: Services not prior authorized by DHW will not be paid or will be subject to recoupment by Idaho Medicaid.

3.4.9 Record Keeping

Each agency is required to maintain a medical record on all services provided to Medicaid participants. See, *IDAPA 16.03.10.136 Psychosocial Rehabilitative Services (PSR) – Record Requirement for Providers; 01 Name through 09 Payment Limitations*, for specific requirements. The records must contain a current treatment plan signed by a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law. Services must be provided in accordance with the current treatment plan, and the medical record must contain all of the following:

- The name of the participant and the provider.
- The date, start time and end time, duration of service, and justification.
- Documentation of service provided, place-of-service, and response of the participant.
- The legible signature and date, with degree credentials listed of the staff member performing the service.
- Documentation of the participant's choice of provider.
- Documentation of review of progress/reassessment and closure of services.

3.4.10 Procedure Codes

Service	Procedure Code	Description
Ongoing community crisis support	**H2011**	Crisis intervention. PA required. 1 Unit = 15 Minutes.
Psychiatric diagnostic interview	**90801**	Psychiatric diagnostic interview examination. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, clinical nurse specialist-psychiatric, psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist. Physicians should use U1 modifier. 1 Unit = 15 Minutes.
Interactive medical psychiatric diagnostic exam	**90802**	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, clinical nurse specialist-psychiatric, psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist. Physicians should use U1 modifier. 1 Unit = 15 Minutes.
Psychological test for diagnosis and evaluation	**96101** No modifier allowed	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities, e.g., WAIS, Rorschach, MMPI) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report. 1 Unit = 1 Hour.
Psychological test for diagnosis and evaluation	**96102** No modifier allowed	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI and WAIS), with qualified healthcare professional interpretation and report, administered by technician per hour of technician time, face-to-face. 1 Unit = 1 Hour.
Psychological test for diagnosis and evaluation	**96103** No modifier allowed	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI) administered by a computer, with qualified healthcare professional interpretation and report. 1 Unit = 1 Test.
Rehabilitative evaluation	**H0031**	MH assessment, by non-physician. 1 Unit = 15 Minutes.
Treatment plan development	**H0032**	MH service plan development, by non-physician. 1 Unit = 15 Minutes.
Medical report (past record)	**90885**	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. 1 Unit = 1 Report.
Medical report (New exam)	**90889**	Preparation of report of patient's psychiatric status, history, treatment or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers. 1 Unit = 1 Report.

Service	Procedure Code	Description
Individual medical psychotherapy	**90804** **90806** **90808**	Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 – 30 minutes face-to-face with patient (**90804**); individual. The code is based on length of time spent with the participant. Providers should select the code that is closest to duration of the session and bill the code as 1 unit. **90806** = 45 - 50 Minutes, and **90808** = 75 - 80 Minutes. PA required.
Group psychotherapy	**90853**	Psychotherapy (other than a multiple – family group), two or more individuals. Physicians should use U1 modifier. No modifier is allowed for other providers. 1 Unit = 15 Minutes. PA required.
Family psychotherapy	**90847**	Family psychotherapy (conjoint psychotherapy) (with patient present). Physicians should use U1 modifier. No modifier is allowed for other providers. 1 Unit = 15 Minutes. PA required.
Family Medical Psychotherapy participant present	**90846**	Family psychotherapy (conjoint psychotherapy) without patient present. Must be face-to-face with at least one family member present; the participant must be the focus of services; goals of treatment must be specified on the participants individualized treatment plan. Physicians should use U1 modifier. No modifier is allowed for other providers. 1 Unit = 15 Minutes
Pharmacologic management	**90862**	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, or clinical nurse specialist-psychiatric. 1 Unit = 1 Visit. PA required.
Individual psychosocial rehabilitative services	**H2017**	PSR services, individual. 1 Unit = 15 Minutes. PA required. Note: PSR services are covered for Medicaid Enhanced Plan participants only.
Group psychosocial rehabilitative services	**H2014** **HQ** Modifier Required	Skills training and development. Physicians should use U1 modifier in addition to U4. 1 Unit = 15 Minutes. PA required.
Collateral contact	**90887**	When 2 persons exchange information with individuals having a primary relationship to the participant. Collateral contact may be face-to-face or by telephone 1 Unit = 15 Minutes. PA required.

Service	Procedure Code	Description
Nursing service office visit	**T1001**	Nursing assessment/evaluation. Includes review of lab results, phone consultations with physician and/or participant regarding participant's present condition, phone contact with physician to obtain prescription refills. Note: These services must appear on treatment plan in order to be reimbursed. 1 Unit = 15 Minutes. PA required.
Blood draw	**36415**	Routine venipuncture for collection of specimen(s). 1 Unit = 1 Visit. PA required.
Injection	**90782**	Therapeutic, prophylactic, or diagnostic injection (specify material injected), subcutaneous or intramuscular. 1 Unit = 1 Injection. PA required.
Medication supply	**J3490**	Unclassified drugs. Specify medication and dosage. Use of this code requires use of National Drug Code (NDC). Note the drug code on the claim form in the comments field or the designated field on an electronic claim form. PA required.
OT evaluation	**97003**	OT evaluation. 1 Unit = 1 evaluation PA required.
OT, individual	**97535**	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, individual. Specify exact time. 1 Unit = 15 Minutes. PA required.
Individual psychotherapy for nursing home participants	**H0004** **U4** Modifier Required	Behavioral health counseling and therapy, individual. Physicians should use U1 modifier in addition to U4. 1 Unit = 15 Minutes. PA required.
Group psychotherapy for nursing facility participants	**90853** **U4** Modifier Required	Psychotherapy, two or more individuals. Physicians should use U1 modifier in addition to U4. 1 Unit = 15 Minutes. PA required.
Family psychotherapy for nursing facility participants	**90847** **U4** Modifier Required	Family psychotherapy (conjoint psychotherapy) (with patient present). Physicians should use U1 modifier in addition to U4. 1 Unit = 15 Minutes. PA required.

3.5 Claim Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.5.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission*, for more information.

3.5.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items, per claim, can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature-on-file
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.5.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.5.3.3 Completing Specific Fields of a CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury, or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit national provider identifier (NPI) number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date(s) of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield **(1** - **4)** for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening Diagnosis and Treatment (EPSDT) Program Screen; see *Section 1.6 EPSDT*, for more information.
24I	ID Qual	Required, if legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	Billing Provider Info and Ph #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or remittance advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.

Field	Field Name	Use	Directions
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.5.3.4 Sample Paper Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS